

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **42281**
Registrar's No. **11331**

FILED JAN 13 1951

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) Abt. 30		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				1. STREET ADDRESS 544 S. Ewing Avenue	
3. NAME OF DECEASED (Type or Print) Willie		a. (First) Gills		c. (Last) Gills	
4. DATE OF DEATH (Month) (Day) (Year) Dec. 31 1950		5. SEX Male 6. COLOR OR RACE Negro			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Unknown 1862		9. AGE (In years last birthday) Abt. 88	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Wabash RR shops		11. BIRTHPLACE (State or foreign country) Unknown, Alabama	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Peter Gills			
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Emma Gill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Louis W. Anderson	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility with Senile Dementia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None		19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION None	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____			
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from 1-17 , 19 50 , to 12-31 , 19 50 , that I last saw the deceased alive on 12-31 , 19 50 , and that death occurred at 7:50a m., from the causes and on the date stated above.					
23a. SIGNATURE M. D. Gills		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 1-2-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/6/51		24c. NAME OF CEMETERY OR CREMATORY St. Peters Cem.	
24d. LOCATION (City, town, or county) (State) St. Louis, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Gates			
25. ADDRESS 4107 Finney Avenue					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

ORRI 10 1900

SEP

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student embalmer No.

Signed _____

John K. Cunningham

Signed.....
Student Embalmer

Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.